ASSETS DECLARATION
PATIENT AND SPOUSE

Michigan Department of Human Services
(Skip if no spouse)

FOR OFFICE USE ONLY

Grantee Name			
Grantee Client ID			
Case Number			
County	District	Section	Unit Specialist

PLEASE PRINT

Patient's Name (First, Middle, Last)	Phone No. of Nursing Home		Spouse's Name (First, Middle, Last)	Spouse's Phone No.	
Address of Nursing Home (Number, Street, Rural Route)			Spouse's Address (Number, Street, Rural Route)		
City	State	Zip Code	City	State	Zip Code
Patient's Birthdate (Mo/Day/Yr)	Patient's Social Security		Spouse's Birthdate (Mo/Day/Yr)	Spouse's Social Security No. *	

This form asks questions about the property or assets owned by you and/or your spouse. This information is needed to determine your eligibility for Medicaid and the amount of assets that can be protected for the benefit of your spouse. Answer the following questions by providing information about all assets owned by your and/or your spouse as of .

ASSETS

1. Does any in your household have any assets (include assets held jointly)?

☐ Yes → Check all types of assets your household has and complete the table ☐ No

☐ Checking/draft accounts
☐ Certificates of Deposit (CD)
☐ Cash on hand or in safe deposit
☐ Trust or annuities
☐ Life estate/life lease
☐ Life Insurance
☐ Burial trust/funeral contract(s)
☐ Money market accounts
☐ Christmas club accounts
☐ Savings, bonds, stocks or mutual funds
☐ Land contract, mortgage or other notes payable to household member
☐ Burial plot(s), casket, etc.
☐ Other assets _____
☐ Savings/share account
☐ Patient trust funds
☐ IRS, KEOGH, 401K or Deferred Compensations accounts(s)
☐ Real estate (including place you live)
☐ Tools and equipment livestock or crops
☐ Health Savings Account

Owner(s) of asset(s)	Type(s) of asset(s)	Balance, amount of value	Name and address (bank, insurance company, etc.)	Account/policy Number, etc.

AUTHORITY: 42 CFR Part 435.
COMPLETION: Voluntary
PENALTY: No Medicaid.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

*Optional if the community spouse is not requesting assistance.

ASSETS

2. Does anyone in your household have any vehicles?

☐ Yes → Check all types of assets your household has and complete the table ☐ No

☐ Car ☐ Truck ☐ Boat ☐ Campers/trailers ☐ Motorcycles ☐ RV ☐ Other Vehicles

Owner(s) (As shown on vehicle title or registration)	Year	Make/Model	Amount Owed

3. Has anyone in your household:

▪ sold or given away property, land, vehicles, stock, bonds, savings, cash, checking, income, etc., closed any accounts or removed or added a name on any asset within 60 months?	☐ Yes → Who: ☐ No
▪ filed a pending lawsuit which may bring money, property, etc.?	☐ Yes → Who: ☐ No
▪ received a one-time cash payment (such as worker's compensation, lottery winnings, insurance settlement, lawsuit award, etc.) within the last 60 months?	☐ Yes → Who: ☐ No
▪ or has anyone acting for any household member, ever put any money, lawsuit settlement, income or assets in a trust, annuity or similar legal device?	☐ Yes → Who: ☐ No

AFFIDAVIT

I swear or affirm that all the information that I have written on this form or told to a specialist is true. I understand that I can be prosecuted for perjury if I have intentionally given false information. I also know that I may be asked to show proof of any information I have given. I also know that if I have intentionally left out of any information or if I have given false information, which causes me to receive assistance I am not entitled to or more assistance than I am entitled to, I can be prosecuted for fraud.

Signature (Patient or Representative)			Date (Month, Day, Year)
Two Witnesses Only If Signed by Mark X	Signature of First Witness	Signature of Second Witness	

NOTE:	If you signed this application on behalf of someone else, complete the information below.

Name (First, Middle, Last)	Phone Number	Relationship to patient	
Street Address	City	State	Zip Code